Review of Systems

Patient Name: _____ Patient File #: _____ Today's Date:_____ /_____/_____

INSTRUCTIONS: Please fill out all of the sections. If none of the conditions apply, select "None."

Constitutional:
☐**None**
☐Chills
☐Daytime Drowsiness
☐Fatigue
☐Fever
☐Night Sweats
☐Weight Gain
☐Weight Loss

Eyes/Vision:
☐**None**
☐Blindness
☐Blurred Vision
☐Cataracts
☐Change in Vision
☐Double Vision
☐Eye Pain
☐Field Cuts
☐Glaucoma
☐Itching *(around the eyes)*
☐Photophobia
☐Tearing
☐Wears Glasses or Contacts

Ears, Nose and Throat:
☐**None**
☐Bleeding
☐Dental Implants
☐Dentures
☐Difficulty Swallowing
☐Discharge
☐Dizziness
☐Ear Drainage
☐Ear Infection*(s)*
☐Ear Pain
☐Fainting
☐Headaches
☐Head Injury *(history of)*
☐Hearing Loss
☐Hoarseness
☐Loss of Smell
☐Nasal Congestion
☐Nose Bleeds
☐Post Nasal Drip
☐Blurred vision (near vision)

Cardiovascular:
☐**None**
☐Angina *(chest pain or discomfort)*
☐Chest Pain
☐Claudication *(leg pain or achiness)*
☐Heart Murmur
☐Heart Problems
☐Orthopnea *(difficulty breathing while lying)*
☐Palpitations *(irregular or forceful heart beat)*
☐Paroxysmal Nocturnal Dyspnea *(shortness of breath at night)*
☐Shortness of Breath
☐Swelling of Leg*(s)*
☐Ulcers
☐Varicose Veins

Gastrointestinal:
☐**None**
☐Abdominal Pain
☐Belching
☐Black, Tarry Stools
☐Constipation
☐Diarrhea
☐Difficulty Swallowing
☐Heartburn
☐Hemorrhoids
☐Indigestion
☐Jaundice *(yellowing of the skin)*
☐Nausea
☐Rectal Bleeding
☐Abnormal Stool Caliber *(quality)*
☐Abnormal Stool Color
☐Abnormal Stool Consistency
☐Vomiting
☐Vomiting Blood

Respiration:
☐**None**
☐Asthma

Endocrine:
☐**None**
☐Cold Intolerance
☐Diabetes
☐Excessive Appetite
☐Excessive Hunger
☐Excessive Thirst
☐Frequent Urination
☐Goiter
☐Hair Loss
☐Heat Intolerance
☐Unusual Hair Growth
☐Voice Changes

Skin:
☐**None**
☐Changes in Nail Texture
☐Changes in Skin Color
☐Hair Growth
☐Hair Loss
☐Hives
☐Itching
☐Paresthesia (numbness, prickling, or tingling)
☐Rash
☐History of Skin Disorders
☐Skin Lesions or Ulcers
☐Varicosities

Nervous System:
☐**None**
☐Dizziness
☐Facial Weakness
☐Headaches
☐Limb Weakness
☐Loss of Consciousness
☐Loss of Memory
☐Numbness
☐Seizures
☐Sleep Disturbance
☐Slurred Speech
☐Stress
☐Strokes
☐Tremors
☐Unsteadiness of Gait

Allergy:
☐**None**
☐Anaphylaxis *(history of)*
☐Food Intolerance
☐Itching
☐Nasal Congestion
☐Sneezing

Hematology:
☐**None**
☐Anemia
☐Bleeding
☐Blood Clotting
☐Blood Transfusion*(s)*
☐Bruises easily
☐Fatigue
☐Lymph Node Swelling

Psychological:
☐**None**
☐Anhedonia *(inability to experience joy or enjoy life)*
☐Anxiety
☐Appetite Changes
☐Behavioral Change*(s)*
☐Bipolar Disorder
☐Confusion
☐Convulsions
☐Depression
☐Insomnia
☐Memory Loss
☐Mood Change*(s)*

Female:
☐**None**
☐Birth Control Therapy
☐Breast Lumps / Pain
☐Burning Urination
☐Cramps
☐Frequent Urination
☐Hormone Therapy
☐Irregular Menstruation
☐Urine Retention
☐Vaginal Bleeding
☐Vaginal Discharge

Male:
☐**None**
☐Burning Urination
☐Erectile Dysfunction
☐Frequent Urination

Patient Signature: _____

FOR OFFICE USE ONLY:

I have reviewed the above ROS with the above named patient: _____ _____
Doctor Signature Date